HAWAIʻI PACIFIC HEALTH | PALI MOMI MEDICAL CENTER

CREATING A HEALTHIER HAWAIʻI

Appointment Scheduled:

Date:_____ Time:_____ AM/PM

By: _____ Location: _____

Scheduling: 535-7000 FAX: (MRI) 485-3148 (CT) 485-4233 (Nuclear Medicine) 488-3852

OUTPATIENT TESTING ORDERS

PATIENT INFORMATION

Patient's Name (Last, First, Middle Initial):	Date of Birth:	Contact Phone:

Patient's Insurance(s)	Authorization #:

PROCEDURE REQUESTED – Please specify body part(s)

☐ CT _____

☐ CTA _____

☐ MRI _____

☐ MRA _____

☐ Angio/IR _____

☐ MBS with Speech Therapist _____

☐ Nuc Med _____

☐ Ultrasound _____

☐ Other _____

SPECIAL INSTRUCTIONS

(MANDATORY) DIAGNOSIS/SYMPTOMS/HISTORY – *"RULE OUT" or "ROUTINE"* not acceptable

ICD-10	Description	Symptoms / History:
_____	_____	
_____	_____	
_____	_____	
_____	_____	

CC REPORTS TO:

☐ Please Provide STAT / WET Read

☐ Patient to Return with CD

ORDERING PHYSICIAN CERTIFICATION

X_____

By signature above, I hereby certify that the procedure(s) requested is/are medically necessary.

Print Physician Name: _____

Phone: _____ Fax: _____

Date: _____ Time: _____AM/

Record Decision Support Information?

-Decision Support Vendor: _____

-Decision Support Adherence:_____

-Decision Support Session ID:_____

-Decision Support Score:_____